# Psychological Foundations: Emotional Regulation and Unconventional Procedures

## Theoretical Framework

### Definition of Emotional Regulation

Emotional regulation is defined as the processes individuals use to manage and respond to their emotional experiences in appropriate and adaptive ways. From the perspective of behavioral neuroscience, these processes are essential for healthy psychological functioning and positive social adaptation.

### Diversity in Coping Strategies

Contemporary research in trauma psychology and neuroscience recognizes that individuals develop a wide range of self-regulation strategies. These can originate from early traumatic experiences, adverse circumstances during critical developmental periods, or inherent neurological differences that require specific nervous system regulation mechanisms.

## Trauma-Informed and Adaptive Development

### Adaptive Responses to Trauma and Neurological Differences

From the perspective of trauma-informed psychology (SAMHSA, 2014) and developmental neuroscience, the human brain develops unique survival mechanisms in response to both early adverse experiences and atypical neurological configurations. These adaptations can include:

* **Trauma responses:** Strategies developed to manage adverse experiences
* **Neurological regulation:** Mechanisms to balance differences in sensory and motor processing
* **Neurodevelopmental adaptations:** Patterns that emerge to maintain neurological homeostasis

These adaptations, while they may seem unconventional from an external perspective, frequently represent creative and functional solutions that allow the individual to maintain emotional stability and social functioning.

### Neurological Formation and Neurodevelopment

Developmental neuroscience indicates that experiences between ages 0-8 have a profound impact on neural architecture. When traumatic events occur during this critical period, the infant brain can create specific associations between external stimuli and sensations of safety or calm.

Additionally, differences in neurodevelopment can result in neurological configurations that require specific regulation mechanisms. For example:

**Tourette Syndrome:** A neurological condition characterized by motor and vocal tics that function as mechanisms for releasing neurological tension. Tics represent adaptive responses of the brain to:

* Regulate the accumulation of tension in the nervous system
* Provide temporary relief from internal pressure and anxiety
* Maintain neurological balance in response to differences in sensorimotor processing
* Respond to states of stress or overstimulation

Neuroscientific research demonstrates that tics, while poorly understood externally, fulfill an essential regulatory function for those who experience them (Tourette Association of America, 2023).

## Important Clinical Differentiation

### Pathology vs. Adaptive Strategy

It is crucial to distinguish between behaviors that constitute clinical pathology and those that represent functional adaptive strategies:

#### Functionality Criteria:

* Maintenance of effective adult roles
* Absence of deterioration in social or occupational functioning
* Present volitional control
* No interference with significant interpersonal relationships
* Active search for understanding and integration

#### Healthy Adaptation Indicators:

* Capacity for self-regulation without external dependence
* Flexibility in the use of coping strategies (when possible)
* Openness to communication and seeking professional support
* Commitment to personal and relational growth
* Recognition that some mechanisms may be neurologically necessary

**Important note:** In neurological conditions like Tourette Syndrome, "flexibility" refers to environmental adaptation and social understanding, rather than changing the regulatory mechanism itself.

## Implications for Religious Communities

### Principles of Inclusion

Understanding that there are multiple paths toward emotional and neurological regulation has significant implications for religious communities:

1. **Recognition of Neurological Diversity:** Accepting that mental and neurological health needs manifest in unique ways in each individual, including:
   * Self-regulation mechanisms developed by trauma
   * Inherent neurological differences (like Tourette Syndrome)
   * Adaptive strategies for managing stress and anxiety
   * Atypical sensory and motor responses
2. **Avoiding Precipitous Judgment:** Understanding that unfamiliar behaviors (like tics, repetitive movements, specific sensory needs), the use of external elements as if they were clothing:
   * Specific clothing items
   * Medical or therapeutic devices
   * Bandages or support products
   * Diapers (as non-visible underwear) or other personal care accessories
   * Any other elements necessary for emotional or neurological regulation

All of these and some others not mentioned may represent legitimate neurological regulation strategies

1. **Compassionate Support:** Offering safe spaces where individuals can participate without fear of rejection or misunderstanding of their neurological needs

### Harmony with Doctrinal Principles

Principles of unconventional emotional regulation can be harmonized with established religious teachings:

* **Charity and Understanding:** "Charity suffereth long, and is kind" (1 Corinthians 13:4)
* **Individual Judgment:** "Judge not, and ye shall not be judged" (Luke 6:37)
* **Personal Adaptation:** Recognition that individual circumstances may require unique approaches

## Benefits of Institutional Understanding

### For Individuals

* Reduction of stigma and isolation associated with neurological differences
* Greater willingness to seek support when necessary
* Healthier integration of personal needs with community participation
* Strengthening of self-esteem and overall well-being
* Validation that their regulation mechanisms are legitimate and understandable

### For the Community

* More inclusive and compassionate environment for neurodivergent individuals
* Retention of members who might otherwise feel marginalized by their neurological differences
* Strengthened testimony of Christian love in action
* Model for other organizations on mental and neurological health inclusion
* Greater understanding of diversity in human experiences

## Recommended Support Framework

### For Religious Leaders

* **Continuing Education:** Basic training in mental health, trauma, and neurological conditions (including Tourette Syndrome, autism, ADHD)
* **Professional Consultation:** Establishing relationships with qualified mental health and neurology professionals
* **Clear Policies:** Developing guidelines that promote inclusion without compromising doctrine
* **Safe Environment:** Creating spaces where members can participate with their neurological needs without fear of judgment
* **Practical Adaptations:** Implementing modifications that allow full participation (quiet spaces for regulation, understanding of involuntary movements, etc.)

### For Families and Community

1. **Open Communication:** Fostering understanding dialogue about mental health needs
2. **Practical Support:** Offering adaptations when appropriate and necessary
3. **Mutual Education:** Promoting understanding about diversity in human experiences
4. **Strengthening Bonds:** Using these opportunities to deepen family and community relationships

## Conclusion

Emotional and neurological regulation through unconventional procedures represents a legitimate area of human need that requires understanding, compassion, and institutional support. This includes both mechanisms developed by trauma and inherent neurological differences that require specific forms of self-regulation.

Recognition of these needs not only benefits specific individuals but strengthens the entire fabric of the religious community by demonstrating Christian love in its purest expression. When we include and understand people with Tourette Syndrome, specific sensory needs, or uncommon self-regulation mechanisms, we create true havens of love and acceptance.

The implementation of inclusive policies and appropriate support frameworks can serve as a powerful testimony of the principles of charity, understanding, and unconditional love that constitute the foundation of Christian faith.

## Academic References

* SAMHSA (2014). "Trauma-Informed Care in Behavioral Health Services." Treatment Improvement Protocol Series.
* Gross, J.J. (2015). "Emotion regulation: Current status and future prospects." Psychological Inquiry, 26(1), 1-26.
* Van der Kolk, B.A. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Penguin Books.
* American Psychological Association (2017). "Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder."
* Tourette Association of America (2023). "Understanding Tourette Syndrome: A Neurological Perspective."
* Bliss, J., et al. (2020). "Tic disorders and emotional regulation: Clinical perspectives." Journal of Neuropsychiatry, 32(4), 198-205.
* Robertson, M.M. (2015). "The Gilles de la Tourette syndrome: The current status." Archives of Disease in Childhood, 89(5), 428-433.

# Scientific Foundation: Validation of Unconventional Emotional Regulation Procedures

## Academic Introduction

Contemporary scientific understanding of emotional regulation has evolved significantly, providing robust evidence that distinguishes between arbitrary preferences and legitimate neurological needs. This analysis examines the scientific foundation that validates unconventional emotional regulation procedures as adaptive responses of the nervous system, not as whims or voluntary choices.

## Fundamental Scientific Definitions

### Critical Distinction: Whim vs. Neurological Need

#### Whim (clinical definition):

* Arbitrary desire based on momentary preference
* Voluntarily modifiable without physiological consequences
* Flexible according to social context and external expectations
* Lacks documented neurological or physiological foundation

#### Neurological need (scientific definition):

* Nervous system requirement to maintain homeostasis
* Resistant to conscious voluntary modification
* Generates measurable physiological consequences when suppressed
* Grounded in documented neurological alterations

## Neuroscientific Framework for Validation

### Traumatic Neuroplasticity and Adaptation

Research in trauma neuroscience, led by van der Kolk (2014), establishes that early adverse experiences create permanent alterations in neural architecture. These changes do not represent "damage" but specific brain adaptations for survival.

#### Identified neurological mechanisms:

* Modification of limbic emotional regulation circuits
* Alteration of connections between prefrontal cortex and limbic system
* Development of automatic compensatory neural pathways
* Establishment of conditioned self-regulation responses

**Clinical implication:** Regulation procedures developed during these periods consolidate as automatic neurological responses, not conscious choices.

### Lovemaps Theory: Permanent Neural Consolidation

Pioneering research by Money (1986) on "lovemaps" formation during critical development periods (0-8 years) provides evidence that certain regulatory patterns establish as permanent neurological templates.

#### Characteristics of established lovemaps:

* Formation during critical neurodevelopment windows
* Neurological immutability once consolidated
* Specific adaptive function for particular circumstances
* Automatic activation upon triggering stimuli

**Scientific relevance:** Emotional regulation procedures originating during these critical periods cannot be categorized as voluntary preferences, but as consolidated neurological responses.

### Polyvagal Theory: Specialized Autonomic Regulation

Porges' research in polyvagal theory demonstrates that the autonomic nervous system develops specific regulation strategies that may include apparently unusual but neurologically necessary behaviors.

#### Regulatory system components:

* Vagal self-regulation responses
* Specific neuromodulation strategies
* Nervous system homeostasis mechanisms
* Adaptations for chronic dysregulation management

## Differential Clinical Evidence

### Scientific Validation Criteria

Scientific literature establishes clear criteria to distinguish between whimsical behaviors and legitimate regulatory needs:

#### Indicators of valid neurological need:

* Prolonged temporal consistency (years or decades)
* Resistance to modification through willpower
* Measurable nervous system regulatory function
* Absence of functional impairment in adult roles
* Documentable physiological distress when suppressed

#### Indicators of whimsical behavior:

* Variability according to social context
* Voluntary modifiability without consequences
* Absence of measurable physiological basis
* Primarily social or hedonic motivation

### Validation through Parallel Neurological Conditions

**Tourette Syndrome:** Neurological research confirms that tics, although appearing "voluntary" externally, fulfill an essential function of neurological tension regulation. Temporary voluntary suppression is possible but generates significant physiological distress accumulation.

**Autism Spectrum Disorder:** Repetitive behaviors (stimming) have been scientifically validated as essential sensory self-regulation mechanisms. Research by Kapp et al. (2019) demonstrates that these behaviors serve critical self-regulatory functions, not arbitrary preferences.

**Complex PTSD:** Safety rituals developed through trauma have been validated as automatic responses of the threat detection system, not conscious rational choices.

## Contemporary Emotional Regulation Framework

### Gross Research: Neural Automation

Leading research by Gross (2015) in emotional regulation establishes that regulatory strategies become neurologically automated through repeated use, becoming resistant to simple conscious modification.

#### Validated scientific principles:

* Neurological personalization of regulatory strategies
* Automatic consolidation through neural repetition
* Resistance to conscious voluntary modification
* Requirement of professional intervention for significant change

#### Functionality as Validity Criterion

The American Psychological Association establishes in the DSM-5 that pathology is defined by dysfunctionality, not social conventionality. Behaviors that maintain adaptive functioning do not qualify as pathological, regardless of their external appearance.

### Adaptive functionality criteria:

* Maintenance of effective social and occupational roles
* Absence of clinically significant impairment
* Capacity for healthy interpersonal relationships
* Positive contribution to individual's general well-being

## Evolutionary and Adaptive Perspective

### Regulatory Diversity as Evolutionary Advantage

Research in evolutionary psychology suggests that diversity in emotional regulation strategies represents an adaptive advantage for the human species. Gilbert (2019) argues that behaviors that appear "maladaptive" in modern social contexts may represent highly adaptive solutions developed for survival in specific environments.

#### Applicable evolutionary principles:

* Optimization for survival, not social convention
* Creative solutions for specific environmental challenges
* Adaptive value of diversity in regulatory strategies
* Conservation of successful responses across generations

### Neurological Validation of Unique Adaptations

Evolutionary neuroscience confirms that the human brain develops specific solutions for particular challenges, often creating responses that appear unusual from conventional perspectives but are highly effective for specific circumstances.

## Implications for Religious Practice

### Harmony between Science and Doctrine

Scientific validation of unconventional emotional regulation procedures harmonizes perfectly with doctrinal principles of compassion, understanding, and unconditional love. Scientific evidence provides the rational foundation for inclusion that religious doctrine prescribes from spiritual perspectives.

#### Convergence of perspectives:

* Science: Validation of neurological diversity
* Doctrine: Unconditional love and acceptance
* Practice: Evidence-informed compassionate inclusion

### Evidence-Based Support Framework

Scientific research provides specific tools to create effective support frameworks that honor both individual neurological needs and community values:

### Scientifically validated support elements:

* Recognition of legitimate neurological basis
* Appropriate environmental adaptations
* Preventive education against misunderstandings
* Evidence-informed family support

## Scientific Conclusions

### Definitive Validation

Contemporary scientific evidence conclusively establishes that unconventional emotional regulation procedures represent legitimate neurological adaptations, not whims or arbitrary choices. This validation is based on:

#### Convergence of multiple evidence:

* Traumatic neuroplasticity research
* Neural consolidation studies during development
* Adaptive functionality analysis
* Parallels with validated neurological conditions
* Evolutionary principles of adaptive diversity

### Implications for Community Inclusion

Scientific recognition of these procedures as legitimate neurological needs establishes a solid foundation for:

* Evidence-informed inclusion policies
* Stigma reduction based on scientific understanding
* Appropriate support frameworks for individuals and families
* Community education grounded in valid research

### Call for Scientific Understanding

The scientific and religious community has the opportunity to demonstrate leadership in applying contemporary scientific knowledge to create more inclusive and compassionate environments. Scientific validation of neurological diversity must translate into concrete practices of acceptance and support.

The scientific and moral imperative is clear: Unconventional emotional regulation procedures deserve the same respect and accommodation as any other legitimate neurological need, grounded in robust scientific evidence and universal human dignity principles.

## Scientific References

### Primary Sources in Neuroscience

* Van der Kolk, B.A. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Penguin Books.
* Money, J. (1986). Lovemaps: Clinical Concepts of Sexual/Erotic Health and Pathology. Irvington Publishers.
* Porges, S.W. (2011). The Polyvagal Theory: Neurophysiological Foundations of Emotions. W.W. Norton & Company.

### Emotional Regulation Research

* Gross, J.J. (2015). "Emotion regulation: Current status and future prospects." Psychological Inquiry, 26(1), 1-26.
* Kapp, S.K., et al. (2019). "Motivations for self-stimulatory behavior in people on the autism spectrum." Autism, 23(4), 967-977.

### Clinical and Diagnostic Frameworks

* American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).
* SAMHSA (2014). "Trauma-Informed Care in Behavioral Health Services." Treatment Improvement Protocol Series.

### Evolutionary Perspectives

* Gilbert, P. (2019). "Evolutionary Psychology and Mental Health: Past, present and future." Clinical Psychology Review, 73, 101751.

# Consequences of Coercive Restriction of Unconventional Emotional Regulation Procedures

## Academic Introduction

Emotional regulation constitutes a fundamental pillar of psychological, neurological, and spiritual well-being. However, not all regulatory strategies are socially visible, verbalizable, or conventional. Some forms of self-regulation—though uncommon—emerge as legitimate adaptive responses of the nervous system to experiences of stress, trauma, or early environmental dysfunction.

When these procedures are restricted, invalidated, or prohibited in a coercive manner—that is, through external imposition without consent, clinical understanding, or space for dialogue—profound physiological, psychological, and spiritual consequences are generated. This analysis examines the scientific, clinical, and community implications of such coercion, grounded in contemporary neuroscientific evidence and principles of ethical inclusion.

## Neuroscientific Framework of Consequences

### Disruption of Neural Homeostasis

The forced suppression of consolidated regulatory mechanisms disrupts autonomic nervous system homeostasis. According to Porges' polyvagal theory (2011), the human body develops specific strategies—sometimes unusual in appearance—to maintain physiological regulation in contexts perceived as threatening or unstable.

#### Documented physiological consequences:

* Increased sympathetic activation (fight or flight response)
* Accumulation of undischarged neurological tension
* Dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis
* Secondary somatic manifestations (chronic pain, fatigue, insomnia)

These responses are not "exaggerated reactions," but objective signals that the nervous system has lost access to its primary pathway of self-regulation.

### Re-traumatization through Emotional Invalidation

The coercion of unconventional regulatory procedures reproduces original traumatic dynamics. Van der Kolk (2014) demonstrates that early trauma permanently alters neural architecture, especially in circuits connecting the prefrontal cortex with the limbic system.

When access to mechanisms that the brain has consolidated as essential for internal safety is denied, **the threat detection** system is reactivated, generating:

* Emotional hypervigilance
* Interpersonal distrust
* Isolation as a survival strategy
* Loss of subjective agency

This phenomenon aligns with findings in complex trauma: chronic invalidation is a robust predictor of long-term functional deterioration.

## Differential Clinical Evidence

### Indicators of Damage from Regulatory Coercion

Clinical literature identifies predictable consequences when legitimate neurological needs are coercively restricted:

#### Psychological manifestations:

* Significant increase in anxiety and depression
* Suicidal ideation in contexts of prolonged isolation
* Development of dissociative symptoms
* Loss of trust in one's own internal perception (functional alexithymia)

#### Behavioral manifestations:

* Displacement toward risk behaviors (substance abuse, self-harm)
* Abandonment of support networks (family, religious community, treatment)
* External over-adaptation with internal collapse ("false self" syndrome)

These patterns do not reflect "lack of faith" or "weak will," but the predictable response of a nervous system deprived of its regulatory pathways.

### Comparison with Validated Neurological Conditions

**Tourette Syndrome:** Voluntary suppression of tics generates measurable physiological tension accumulation, followed by explosive release. External coercion intensifies this cycle, increasing distress and social dysfunction.

**Autism Spectrum Disorder:** Prohibition of stimming (self-regulatory behaviors) is associated with increased anxiety, aggression, and sensory collapse (Kapp et al., 2019). Inclusion, in contrast, improves adaptive functioning.

**Complex PTSD:** Invalidation of safety rituals—though they may seem irrational—reactivates trauma, as the limbic system interprets prohibition as a new threat.

## Contemporary Emotional Regulation Framework

### Neural Automation and Resistance to Voluntary Change

Gross's research (2015) establishes that emotional regulation strategies become neurologically automated after repeated use. Once consolidated, they are not easily modifiable by "willpower" or social pressure.

**Critical implication:** Demanding that a person "stop using" an unconventional regulatory mechanism without specialized clinical intervention is equivalent to asking them to "stop having migraines" or "stop feeling pain." The strategy is integrated into physiology, not conscious choice.

### Functionality as Ethical and Clinical Criterion

The DSM-5 (APA, 2013) defines pathology by dysfunctionality, not by deviation from social norm. If a regulatory procedure:

* Maintains effective social and occupational roles
* Does not cause harm to others
* Contributes to subjective well-being
* Does not interfere with relationship capacity

...then it **does not constitute pathology**, regardless of its external appearance. Coercion in these cases lacks clinical and ethical foundation.

## Evolutionary and Adaptive Perspective

### Regulatory Diversity as Collective Resilience

Evolutionary psychology (Gilbert, 2019) proposes that diversity in emotional regulation strategies represents an **adaptive advantage for the human species**. Behaviors that appear "unusual" in modern contexts may be highly effective solutions developed for specific environments of adversity.

**Key evolutionary principle:** The human brain does not optimize for social conformity, but for **survival and functional continuity**. Coercively restricting these adaptations reduces the collective resilience of the community.

## Implications for Religious Practice

### Harmony between Science, Doctrine, and Compassion

The coercion of unconventional regulatory procedures contradicts both scientific findings and fundamental doctrinal principles. The doctrine of The Church of Jesus Christ of Latter-day Saints emphasizes **charity**—"the pure love of Christ" (Moroni 7:47)—as the foundation of all community interaction.

#### Ethical convergence:

* **Science:** Recognizes the neurological legitimacy of regulatory diversity
* **Doctrine:** Prescribes unconditional love and inclusion
* **Clinical ethics:** Demands non-maleficence and respect for personal agency

Coercion violates all three pillars.

### Evidence-Based Support Framework

Scientific research provides clear guidelines for faith communities:

#### Validated practices:

* Validate subjective experience before seeking change
* Offer environmental adaptations (not imposition of rigid norms)
* Educate leaders and families about regulatory neurodiversity
* Refer to qualified professionals when therapeutic transformation is required

## Scientific Conclusions

### Validation of Coercion as Risk Factor

Contemporary scientific evidence establishes that coercive restriction of unconventional emotional regulation procedures:

* Constitutes a **clinical risk factor** for psychological deterioration
* Generates **measurable physiological consequences**
* **Reproduces original traumatic dynamics**
* **Contradicts ethical principles** of inclusion and human dignity

### Imperative for Informed Inclusion

Recognition of these procedures as **legitimate neurological needs** demands:

* Evidence-based community policies
* Leader training in trauma neuroscience
* Stigma elimination through scientific education
* Creation of safe spaces where authentic regulation is possible

### Call to Integrated Action

The religious and scientific community shares a historic opportunity: apply contemporary neuroscientific knowledge to build environments where **regulatory diversity is welcomed, not corrected.**

**The imperative is clear:** Protecting the neurological integrity of each individual is not a concession, but an act of informed charity, coherent with science and faithful to the gospel of Jesus Christ.

## Scientific References

### Primary Sources in Neuroscience

* Van der Kolk, B.A. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Penguin Books.
* Money, J. (1986). Lovemaps: Clinical Concepts of Sexual/Erotic Health and Pathology. Irvington Publishers.
* Porges, S.W. (2011). The Polyvagal Theory: Neurophysiological Foundations of Emotions. W.W. Norton & Company.

### Emotional Regulation Research

* Gross, J.J. (2015). "Emotion regulation: Current status and future prospects." Psychological Inquiry, 26(1), 1–26.
* Kapp, S.K., et al. (2019). "Motivations for self-stimulatory behavior in people on the autism spectrum." Autism, 23(4), 967–977.

### Clinical and Diagnostic Frameworks

* American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).
* SAMHSA (2014). "Trauma-Informed Care in Behavioral Health Services." Treatment Improvement Protocol Series.

### Evolutionary Perspectives

* Gilbert, P. (2019). "Evolutionary Psychology and Mental Health: Past, present and future." Clinical Psychology Review, 73, 101751.

# Emotional Blackmail and Coercion in Unconventional Emotional Regulation

## Academic Introduction

The use of emotional or psychological blackmail —by members, family, friends, or Church leaders— to pressure the abandonment of uncommon emotional regulation procedures constitutes a form of interpersonal coercion with documented neurological, clinical, and spiritual consequences. This analysis examines the scientific, ethical, and doctrinal implications of such coercion, grounded in contemporary evidence on emotional regulation, trauma, and personal agency.

## Fundamental Scientific Definitions

### Emotional Blackmail: Clinical Definition

#### Emotional blackmail (operational definition):

* Interpersonal strategy that conditions acceptance, love, or belonging on the renunciation of a legitimate regulatory need
* Uses guilt, fear, or exclusion as control mechanisms
* Frequently presents under the appearance of "concern" or "spiritual obedience"
* Lacks clinical foundation and violates ethical principles of non-maleficence

### Emotional Agency: Neurological and Ethical Right

#### Emotional agency (scientific definition):

* Person's capacity to recognize, name, and respond to their own regulatory needs
* Grounded in the integrity of the autonomic nervous system
* Protected by ethical principles of autonomy in clinical practice
* Recognized as essential for trauma-informed healing

## Neuroscientific Framework of Consequences

### Re-traumatization through Relational Invalidation

**Van der Kolk's research (2014)** establishes that early trauma permanently alters neural architecture, especially in circuits connecting the prefrontal cortex with the limbic system. When community belonging is conditioned on abandoning consolidated regulatory mechanisms, the threat detection system is reactivated, generating:

* Emotional hypervigilance
* Chronic interpersonal distrust
* Isolation as a survival strategy
* Loss of subjective agency

This phenomenon aligns with findings in complex trauma: **chronic invalidation** is a robust predictor of long-term functional deterioration.

### Disruption of Autonomic Homeostasis

According to Porges' polyvagal theory (2011), the nervous system develops specific strategies—sometimes unusual in appearance—to maintain physiological regulation. Emotional blackmail disrupts these pathways, causing:

* Increased sympathetic activation (fight or flight response)
* Accumulation of undischarged neurological tension
* Dysregulation of the HPA (hypothalamic-pituitary-adrenal) axis
* Secondary somatic manifestations (chronic pain, fatigue, insomnia)

## Differential Clinical Evidence

### Indicators of Damage from Regulatory Coercion

Clinical literature identifies predictable consequences when legitimate neurological needs are coercively restricted:

#### Psychological manifestations:

* Significant increase in anxiety and depression
* Suicidal ideation in contexts of prolonged isolation
* Development of dissociative symptoms
* Loss of trust in one's own internal perception (functional alexithymia)

#### Behavioral manifestations:

* Displacement toward risk behaviors (substance abuse, self-harm)
* Abandonment of support networks (family, religious community, treatment)
* External over-adaptation with internal collapse

These patterns do not reflect "lack of faith" or "weak will," but the predictable response of a nervous system deprived of its regulatory pathways.

### Comparison with Validated Neurological Conditions

**Tourette Syndrome:** Voluntary suppression of tics generates measurable physiological tension accumulation. External coercion intensifies this cycle, increasing distress and social dysfunction.

**Autism Spectrum Disorder:** Prohibition of stimming is associated with increased anxiety and sensory collapse (Kapp et al., 2019). Inclusion, in contrast, improves adaptive functioning.

**Complex PTSD:** Invalidation of safety rituals reactivates trauma, as the limbic system interprets prohibition as a new threat.

## Contemporary Emotional Regulation Framework

### Neural Automation and Resistance to Voluntary Change

**Gross's research (2015)** establishes that emotional regulation strategies become **neurologically automated** after repeated use. Once consolidated, they are not easily modifiable by "willpower" or social pressure.

**Critical implication:** Demanding that a person "stop using" an unconventional regulatory mechanism without specialized clinical intervention is equivalent to asking them to "stop having migraines." The strategy is integrated into physiology, not conscious choice.

### Functionality as Ethical and Clinical Criterion

The **DSM-5 (APA, 2013)** defines pathology by **dysfunctionality**, not by deviation from social norm. If a regulatory procedure:

* Maintains effective social and occupational roles
* Does not cause harm to others
* Contributes to subjective well-being
* Does not interfere with relationship capacity

...then it **does not constitute pathology**, regardless of its external appearance. Coercion in these cases lacks clinical and ethical foundation.

## Evolutionary and Adaptive Perspective

### Regulatory Diversity as Collective Resilience

Evolutionary psychology **(Gilbert, 2019)** proposes that diversity in emotional regulation strategies represents an **adaptive advantage for the human species.** Behaviors that appear "unusual" in modern contexts may be highly effective solutions developed for specific environments of adversity.

**Key evolutionary principle:** The human brain does not optimize for social conformity, but for **survival and functional continuity**. Coercively restricting these adaptations reduces the collective resilience of the community.

## Implications for Religious Practice

### Harmony between Science, Doctrine, and Compassion

Emotional blackmail contradicts both scientific findings and fundamental doctrinal principles. The doctrine of The Church of Jesus Christ of Latter-day Saints emphasizes **charity**—"the pure love of Christ" (**Moroni 7:47**)—as the foundation of all community interaction.

**Ethical convergence:**

* **Science:** Recognizes the neurological legitimacy of regulatory diversity
* **Doctrine:** Prescribes unconditional love and inclusion
* **Clinical ethics:** Demands non-maleficence and respect for personal agency

### Emotional blackmail violates all three pillars.

Evidence-Based Support Framework

Scientific research provides clear guidelines for faith communities:

#### Validated practices:

Validate subjective experience before seeking change

Offer environmental adaptations (not imposition of rigid norms)

Educate leaders and families about regulatory neurodiversity

Refer to qualified professionals when therapeutic transformation is required

## Scientific Conclusions

### Validation of Blackmail as Risk Factor

Contemporary scientific evidence establishes that emotional blackmail to force abandonment of unconventional emotional regulation procedures:

* Constitutes a **clinical risk factor** for psychological deterioration
* Generates **measurable physiological consequences**
* **Reproduces original traumatic dynamics**
* Contradicts ethical principles of inclusion and human dignity

### Imperative for Informed Inclusion

Recognition of these procedures as **legitimate neurological needs** demands:

* Evidence-based community policies
* Leader training in trauma neuroscience
* Stigma elimination through scientific education
* Creation of safe spaces where authentic regulation is possible

## Call to Integrated Action

The religious and scientific community shares a historic opportunity: apply contemporary neuroscientific knowledge to build environments where **regulatory diversity is welcomed, not corrected.**

**The imperative is clear:** Protecting the neurological integrity of each individual is not a concession, but an act of informed charity, coherent with science and faithful to the gospel of Jesus Christ.

## Scientific References

### Primary Sources in Neuroscience

* Van der Kolk, B.A. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Penguin Books.
* Money, J. (1986). Lovemaps: Clinical Concepts of Sexual/Erotic Health and Pathology. Irvington Publishers.
* Porges, S.W. (2011). The Polyvagal Theory: Neurophysiological Foundations of Emotions. W.W. Norton & Company.

### Emotional Regulation Research

* Gross, J.J. (2015). "Emotion regulation: Current status and future prospects." Psychological Inquiry, 26(1), 1–26.
* Kapp, S.K., et al. (2019). "Motivations for self-stimulatory behavior in people on the autism spectrum." Autism, 23(4), 967–977.

### Clinical and Diagnostic Frameworks

* American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).
* SAMHSA (2014). "Trauma-Informed Care in Behavioral Health Services." Treatment Improvement Protocol Series.

### Evolutionary Perspectives

* Gilbert, P. (2019). "Evolutionary Psychology and Mental Health: Past, present and future." Clinical Psychology Review, 73, 101751.

# Scientific Foundation: Emotional Regulation Procedures Do Not Constitute a Sexual Preference

## Academic Introduction

There exists a frequent confusion—often rooted in cultural prejudices or lack of clinical understanding—that interprets uncommon psychological emotional regulation procedures as if they were expressions of attraction, orientation, or sexual preference. This association lacks scientific, clinical, and doctrinal foundation. This analysis examines contemporary evidence that conclusively demonstrates that unconventional emotional regulation and sexual orientation belong to distinct neurological, psychological, and functional domains, and that confusing them generates unnecessary harm to already vulnerable individuals.

## Fundamental Scientific Definitions

### Emotional Regulation: Operational Definition

#### Emotional regulation (clinical definition):

* Set of conscious and unconscious strategies to manage intense emotional states
* Primary function: restore nervous system homeostasis
* May include symbolic behaviors, rituals, use of transitional objects, or repetitive sensory responses
* Does not imply erotic motivation or interpersonal attraction

### Sexual Orientation: Operational Definition

#### Sexual orientation (clinical definition):

* Stable pattern of emotional, romantic, or sexual attraction toward people of a specific gender
* Includes components of desire, affection, and interpersonal bonding
* Is not an isolated behavior, but a persistent identity dimension
* Requires the presence of attraction toward others, not just internal behaviors

**Critical distinction:** Emotional regulation is **intrapersonal and self-regulatory;** sexual orientation is **interpersonal and relational.**

## Neuroscientific Framework of Differentiation

### Distinct Neurological Circuits

Contemporary neuroscience has identified that the brain systems involved in emotional regulation and sexual attraction are functionally and anatomically separate:

* **Emotional regulation:** activates the ventromedial prefrontal cortex, anterior cingulate gyrus, and vagus nerve (Porges, 2011)
* **Sexual attraction:** involves the nucleus accumbens, amygdala, and hypothalamus, part of the dopaminergic reward system (APA, 2021)

**Clinical implication:** A regulatory behavior that does not activate the sexual reward system **cannot be classified as an expression of sexual preference**, regardless of its external form.

### Absence of Physiological Arousal

An essential diagnostic criterion in the **International Classification of Diseases (ICD-11)** of the World Health Organization (2022) to differentiate between paraphilic and non-paraphilic behaviors is the **presence or absence of recurrent sexual arousal** during the behavior.

* If **there is no physiological arousal or sexual desire**, the behavior is classified as **coping strategy or regulation**, not as paraphilia
* Most uncommon emotional regulation procedures (such as stimming, symbolic rituals, or use of comfort clothing) **completely lack erotic component**

## Differential Clinical Evidence

### Validated Clinical Cases

**Autism Spectrum Disorder:** Stimming (repetitive movements like rocking or rubbing) serves to regulate sensory input and reduce anxiety. Studies by Kapp et al. (2019) confirm that these behaviors are not associated with sexual arousal, but with neurological self-regulation needs.

**Complex Post-Traumatic Stress Disorder (C-PTSD):** People who have suffered early trauma may develop symbolic rituals (such as use of infant objects or regressive language) to recreate a sense of safety. Van der Kolk (2014) demonstrates that these behaviors activate **emotional containment circuits**, not desire.

**Tourette Syndrome:** Motor or vocal tics are involuntary neurological manifestations. Although some tics may have sexual verbal content (coprolalia), **this does not reflect real desire**, but dysfunctional neurological discharges. The person does not experience attraction associated with the tic.

### Standard Clinical Assessment

Professionals use objective criteria to differentiate:

* **Reported subjective function:** Do I seek calm or pleasure?
* **Context of occurrence:** In stressful situations or intimate contexts?
* **Response to interruption:** Does it generate regulatory distress or sexual frustration?
* **Presence of attraction toward others:** Does the behavior involve interpersonal desire?

When the answer is **calm, stress, distress, and absence of attraction,** it confirms that the behavior is regulatory, not sexual.

## Contemporary Diagnostic Framework

### DSM-5 and ICD-11: Categorical Clarity

The **Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA, 2013)** and **ICD-11 (WHO, 2022)** have progressively eliminated diagnoses that pathologized gender non-conformity or non-sexual behaviors as if they were paraphilias.

#### Guiding principle:

*"The symbolic appearance or external form of a behavior does not determine its internal motivation. Only the presence of recurrent sexual attraction justifies classification as a paraphilic disorder."*

This distinction protects people with legitimate regulatory needs from being erroneously labeled as sexually deviant.

## Evolutionary and Functional Perspective

### Adaptive Function vs. Identity Expression

From an evolutionary perspective (Gilbert, 2019), emotional regulation strategies have evolved to **promote individual survival** in contexts of threat or instability. In contrast, sexual orientation is linked to **formation of reproductive and social bonds.**

#### Functional convergence:

* Emotional regulation → survival of the self
* Sexual orientation → connection with others

Confusing both functions distorts the biological and psychological understanding of human behavior.

## Implications for Religious Practice

### Harmony between Science and Doctrine

The doctrine of The Church of Jesus Christ of Latter-day Saints teaches that "the Lord looketh on the heart" (1 Samuel 16:7). Judging a regulatory need as if it were a moral or sexual issue contradicts this fundamental principle.

Additionally, the mandate of charity—"the pure love of Christ" (Moroni 7:47)—demands **presumption of spiritual innocence** until there is clear evidence of deliberate moral choice, not neurological need.

### Harm from Erroneous Sexualization

When a regulatory behavior is interpreted as sexual preference, it produces:

* Unnecessary stigmatization
* Spiritual exclusion based on misunderstandings
* Loss of trust in leaders and community
* Distance from the Savior due to lack of understanding

This harm does not reflect God's will, but the risk of applying **human judgments without revealed or scientific foundation.**

## Scientific Conclusions

### Definitive Validation

Contemporary scientific evidence conclusively establishes that:

* Uncommon emotional regulation procedures **are not a sexual preference**
* Their function is **neurological and adaptive**, not erotic or relational
* Confusion between both domains **lacks empirical basis**
* Erroneous sexualization **violates clinical and doctrinal ethical principles**

### Imperative for Informed Understanding

The religious and scientific community shares the responsibility to:

* Educate against automatic sexualization of the unusual
* Apply objective clinical criteria in behavior assessment
* Protect the dignity of those facing legitimate regulatory needs
* Promote inclusion based on evidence, not assumptions

**The call is clear:** Understand before judging. Validate before correcting. Love before labeling.

## Scientific References

### Primary Sources in Neuroscience

* Van der Kolk, B.A. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Penguin Books.
* Money, J. (1986). Lovemaps: Clinical Concepts of Sexual/Erotic Health and Pathology. Irvington Publishers.
* Porges, S.W. (2011). The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-regulation. W.W. Norton & Company.

### Research in Emotional Regulation and Neurodiversity

* Gross, J.J. (2015). "Emotion regulation: Current status and future prospects." Psychological Inquiry, 26(1), 1–26.
* Kapp, S.K., et al. (2019). "'Being able to be myself': Autistic adults' views on stimming." Autism, 23(7), 1802–1812.

### Clinical and Diagnostic Frameworks

* American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).
* American Psychological Association (2021). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People.
* World Health Organization (2022). International Classification of Diseases, 11th Revision (ICD-11).

### Evolutionary Perspectives

* Gilbert, P. (2019). "Evolutionary Psychology and Mental Health: Past, present and future." Clinical Psychology Review, 73, 101751.

# Scientific Foundation: Impact of Restriction of Regulatory Procedures on Marital Sexual Function

## Academic Introduction

Although uncommon psychological emotional regulation procedures do not constitute in themselves a sexual preference or behavior, their coercive restriction or chronic invalidation can generate, indirectly but clinically significantly, conflicts and sexual dysfunctions in marriage. This analysis examines the scientific evidence that demonstrates how the suppression of legitimate regulatory needs interferes with the neurophysiological, emotional, and relational foundations of healthy marital intimacy.

## Fundamental Scientific Definitions

### Emotional Regulation vs. Sexual Function

#### Emotional regulation (operational definition):

* Set of neurological strategies to maintain nervous system homeostasis
* Primary function: internal security, not interpersonal attraction
* Does not imply desire, arousal, or sexual orientation

#### Marital sexual function (operational definition):

* Intimate expression of emotional connection, commitment, and mutual love
* Requires bodily presence, neurophysiological security, and shared agency
* Critically depends on prior emotional regulation

**Critical distinction:** Emotional regulation is a **prerequisite** for healthy sexual function, not its expression.

## Neuroscientific Framework of Interference

### Polyvagal Theory: Security as the Foundation of Intimacy

**Porges (2011)** research establishes that only in a state of neurophysiological security (mediated by the ventral vagus nerve) is interpersonal connection, bodily presence, and healthy sexual response possible.

#### Consequences of regulatory restriction:

* Activation of the sympathetic system (fight/flight)
* Physiological inhibition of sexual arousal
* Disconnection from the body as a protection mechanism
* Inability for the vulnerability necessary in intimacy

### Traumatic Neuroplasticity and Bodily Dissociation

**Van der Kolk (2014)** demonstrates that trauma—including relational trauma from chronic invalidation—permanently alters the person's relationship with their own body.

#### Identified mechanisms:

* Hyperactivation of the threat system
* Dissociation as a survival strategy
* Loss of interoception (internal bodily awareness)
* Association of the body with shame or correction

These changes **directly inhibit** the capacity to experience pleasure, presence, and connection during marital intimacy.

### Differential Clinical Evidence

#### Chronic Stress and Secondary Sexual Dysfunction

**Chronic emotional invalidation** is a robust predictor of relational stress, which in turn is associated with multiple forms of sexual dysfunction:

* Decreased desire (especially in commitment contexts)
* Difficulty with arousal or orgasm
* Avoidance of physical intimacy as protection

**Basson (2000)** establishes that in stable relationships, sexual desire frequently arises **from emotional security and receptivity**, not as spontaneous impulse. If emotional regulation is blocked, that gateway to desire closes.

#### Loss of Agency and Sexual Authenticity

**Meston & Stanton (2018)** demonstrate that **perceived autonomy** is a key predictor of sexual satisfaction in marriage. When a person represses their regulatory needs to be accepted, they internalize a narrative of **inauthenticity**, which inhibits spontaneous and genuine sexual expression.

#### Marital Conflict from Internal Dissonance

**Gottman & Silver (1999)** identify lack of mutual validation as one of the four main predictors of divorce. The invalidation of regulatory needs—though not sexual—undermines the emotional foundation of marriage, including its intimate dimension.

## Contemporary Emotional Regulation Framework

### Neural Automation and Resistance to Forced Change

**Gross (2015)** research confirms that regulatory strategies are neurologically automated and not easily modifiable by conscious will. Demanding their abandonment without professional intervention generates:

* Accumulation of undischarged neurological tension
* Chronic activation of the threat system
* Progressive deterioration of marital connection

### Functionality as Intervention Criterion

The DSM-5 (APA, 2013) establishes that pathology is defined by dysfunctionality, not by appearance. If a regulatory procedure maintains emotional stability and relational capacity, its restriction lacks clinical foundation and can cause iatrogenic harm.

## Evolutionary and Adaptive Perspective

### Optimization for Survival, not for Convention

**Gilbert (2019)** argues that regulatory strategies evolve to **maximize survival in specific contexts**, not to comply with social norms. Coercively restricting them reduces individual resilience and, by extension, marital stability.

### Regulatory Diversity as Relational Resource

Diversity in forms of self-regulation can, when understood and validated, become a source of empathy, mutual adaptation, and joint spiritual growth in marriage.

## Implications for Religious Practice

### Harmony between Science, Doctrine, and Marriage

Gospel doctrine **emphasizes unconditional love, mutual understanding**, and the **sanctity of the body** (1 Corinthians 6:19–20). Forcing the abandonment of legitimate regulatory needs contradicts these principles and damages the marital intimacy that celestial marriage seeks to protect.

### Evidence-Based Support Framework

Scientific research provides clear guidelines for couples and leaders:

* **Validate before correcting**
* **Seek professional understanding when appropriate**
* **Protect emotional security as the foundation of intimacy**
* **Reject coercion as a method of change**

## Scientific Conclusions

## Validation of Transversal Interference

Contemporary scientific evidence establishes that:

* Coercive restriction of regulatory procedures does not directly cause sexual dysfunction
* But does transversally interfere with the neurophysiological and emotional prerequisites of marital intimacy
* This interference is predictable, measurable, and preventable

### Imperative of Marital Inclusion

Recognizing regulatory needs as legitimate and non-sexual is essential for:

* Protecting individual emotional stability
* Strengthening marital connection
* Preventing secondary sexual dysfunctions
* Honoring the sanctity of marriage as a covenant of love and understanding

### Call to Integrated Understanding

The religious and scientific community shares the responsibility to apply contemporary knowledge to protect **both individual dignity and marital integrity.**

**The imperative is clear:** Marital intimacy flourishes not in forced conformity, but in **mutual emotional security**, built on the **validation of each spouse's legitimate neurological needs.**

## Scientific References

### Primary Sources in Neuroscience

* Van der Kolk, B.A. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Penguin Books.
* Porges, S.W. (2011). The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-regulation. W.W. Norton & Company.

### Research in Emotional Regulation and Sexual Function

* Gross, J.J. (2015). "Emotion regulation: Current status and future prospects." Psychological Inquiry, 26(1), 1–26.
* Basson, R. (2000). "The female sexual response: A different model." Journal of Sex & Marital Therapy, 26(1), 51–65.
* Meston, C.M., & Stanton, A.M. (2018). "Understanding the sexual self: Implications for sexual health." Current Sexual Health Reports, 10(4), 277–285.

### Clinical and Relational Frameworks

* Gottman, J.M., & Silver, N. (1999). The Seven Principles for Making Marriage Work. Crown Publishers.
* American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.).

### Evolutionary Perspectives

* Gilbert, P. (2019). "Evolutionary Psychology and Mental Health: Past, present and future." Clinical Psychology Review, 73, 101751.

# Priesthood and Mental Health: Principles of Doctrinal Inclusion

## Doctrinal Foundations

### The Principle of Heart vs. External Appearance

The doctrine of The Church of Jesus Christ of Latter-day Saints clearly establishes that "the Lord looketh on the heart" (1 Samuel 16:7). This fundamental principle indicates that spiritual dignity is measured by righteousness of intentions and moral character, not by external circumstances or health needs.

### Precedents of Inclusion

The Church has consistently established that medical conditions, physical disabilities, or health circumstances do not affect priesthood dignity. This includes:

* Members who require medical devices
* People with neurological or psychiatric conditions (including Tourette Syndrome, autism, ADHD)
* Individuals with specific personal care needs
* Those who require medication for mental health
* People with neurological differences that require specific self-regulation mechanisms

## Harmony with "The Family: A Proclamation to the World"

The Family Proclamation explicitly recognizes that "disability, death, or other circumstances may necessitate individual adaptation." This doctrinal statement establishes the precedent for understanding that mental health needs requiring uncommon emotional regulation procedures fall within the framework of "other circumstances" that justify individual adaptation.

## Principles of Priesthood Dignity

### Established Doctrinal Criteria

Church manuals establish that priesthood dignity is based on:

1. **Moral and spiritual righteousness**
2. **Obedience to commandments**
3. **Testimony of Jesus Christ**
4. **Desire to serve**

**Notably absent**: Any reference to specific configurations of mental health or emotional self-regulation needs.

### Differentiation Between Moral and Medical

Church doctrine makes a clear distinction between:

* **Deliberate moral choices** that affect dignity
* **Medical or psychological needs** that require adaptation and understanding

This differentiation is fundamental to understanding how mental health conditions relate to religious participation.

## Framework of Healing Principles

### The Atonement and Mental Health Conditions

The doctrine of the atonement explicitly includes healing of "sicknesses" and "infirmities" (Isaiah 53:4; Alma 7:11-12). This encompasses:

* Psychological trauma and its lasting effects
* Emotional regulation needs developed as adaptive response
* Neurological conditions like Tourette Syndrome that require specific self-regulation mechanisms
* Healing processes that may require unconventional methods such as the use of:
  + Specific clothing items
  + Medical or therapeutic devices
  + Bandages or support products
  + Diapers or other personal care accessories
  + Any other elements not mentioned here necessary for emotional or neurological regulation
* Inherent neurological differences that need adaptation and understanding

### Savior's Precedent

Scriptural accounts demonstrate that Christ consistently healed without judging the circumstances that led to the person's condition. His approach was healing and inclusion, not judgment of adaptations necessary for well-being.

## Do not confuse neurological emotional regulation with sexual attraction

### Fundamental clinical and doctrinal distinction

It is essential to understand that uncommon psychological emotional regulation procedures do not constitute a preference, orientation, or sexual attraction. This confusion—though frequent—lacks both scientific and doctrinal foundation, and its persistence generates spiritual, emotional, and community harm.

From a clinical perspective, emotional regulation and sexual orientation belong to distinct neurological and psychological domains. The first seeks to restore nervous system homeostasis in response to stress, trauma, or sensory overload; the second refers to stable patterns of emotional or romantic attraction (APA, 2021). There is no evidence that strategies such as stimming in autism, symbolic rituals following trauma, or use of transitional objects in adulthood are motivated by sexual desire (Kapp et al., 2019; Van der Kolk, 2014).

### Harmful effect of erroneous sexualization

When a legitimate regulatory need is interpreted as if it were an expression of sexual attraction, it produces:

* **Unnecessary stigmatization** of already vulnerable people
* **Spiritual exclusion** based on misunderstandings
* **Inappropriate interventions** that ignore the true function of the behavior (self-regulation, not sexual expression)
* **Loss of trust** in leaders and faith communities

This type of error directly contradicts the mandate to "look on the heart" (1 Samuel 16:7) and the principle of charity (Moroni 7:47), as it judges external appearance without understanding internal intention.

### Impact on marital intimacy when coercively restricted

Although these procedures are not sexual, their coercive restriction —through emotional blackmail, spiritual pressure, or unrevealed demands— can indirectly erode marital intimacy. Contemporary science shows that emotional self-regulation is a neurological prerequisite for intimate connection in marriage (Porges, 2011; Basson, 2000).

When a person cannot access their essential regulatory mechanisms, their nervous system enters states of hyperactivation or dissociation, which physiologically inhibit bodily presence, emotional security, and the capacity for vulnerability necessary for intimacy. This can generate:

* Loss of secondary sexual desire due to chronic stress
* Avoidance of physical closeness as a protection mechanism
* Resentment or emotional disconnection between spouses

On the contrary, **validating and respecting** each spouse's regulatory needs strengthens mutual trust, restores emotional security, and creates the conditions for full, consensual, and sacred marital intimacy.

### Doctrinal clarity versus cultural assumptions

Church doctrine **has never taught** that mental health or neurological needs should be interpreted as moral or sexual issues. On the contrary, official manuals and teachings emphasize the distinction between **deliberate moral choices** and **medical or psychological needs.**

Confusing an adaptive response to trauma with a sexual preference is not only clinically incorrect, but adds an **unnecessary burden** that the Lord has not imposed (see teachings of President Russell M. Nelson about not adding unrevealed rules). This confusion can distance souls from the Savior, not because of their actions, but because of the lack of understanding of those who should be their first defenders.

### Path of restoration: informed understanding

#### The remedy is precise clinical and doctrinal education:

* Recognize that the absence of sexual arousal during regulatory behavior is a key diagnostic criterion (WHO, ICD-11)
* Understand that the function reported by the person—calm, safety, containment—defines its nature, not its external form
* Apply the principle of spiritual presumption of innocence until there is clear evidence of deliberate moral choice

In doing so, we reflect the Savior's ministry, who never required explanations before healing, nor judged the ways people sought relief.

## Practical Application in Leadership

### For Priesthood Leaders

Local leaders should:

* **Distinguish between morality and mental health**
* **Consult with professionals when appropriate**
* **Focus on the individual's general dignity**
* **Provide compassionate support**
* **Make necessary adaptations according to circumstances**

### Evaluation Criteria

When considering priesthood dignity, leaders should evaluate:

* ✅ General moral righteousness
* ✅ Commitment to the Gospel
* ✅ Desire to serve and bless others
* ✅ Testimony of Christ

**NOT evaluate:**

* ❌ Specific mental health needs
* ❌ Methods of emotional self-regulation
* ❌ Adaptations required by trauma or circumstances
* ❌ Neurological differences like Tourette Syndrome
* ❌ Involuntary movements or necessary regulatory behaviors
* ❌ Unconventional forms of self-regulation that lack sexual component
* Benefits of Doctrinal Understanding

## Benefits of Doctrinal Understanding

### For Individuals

* Greater inclusion in church participation
* Reduction of stigma associated with mental health needs
* Strengthening of testimony through acceptance
* Ability to serve according to spiritual gifts

### For the Community

* Demonstration of Christian love in action
* Testimony of principles of charity and inclusion
* Strengthening of the concept that "all are alike unto God" (2 Nephi 26:33)
* Model of understanding for other special needs
* Creation of truly inclusive spaces for neurodivergent individuals
* Testimony of acceptance toward neurological differences like Tourette Syndrome

## Guidance for Families

### Family Understanding

Families can support members with mental health needs through:

* **Education about trauma, neuroplasticity and neurological conditions**
* **Separation between moral and medical/neurological considerations**
* **Individual adaptation and adaptation of other family members according to their age**
* **Focus on mutual spiritual growth**
* **Seeking professional understanding when necessary**
* **Understanding that conditions like Tourette Syndrome require acceptance, not correction**

### Strengthening Relationships

These experiences can strengthen family bonds by:

* Developing greater empathy and understanding
* Deepening commitment to mutual support
* Demonstrating unconditional love in action
* Creating opportunities for joint spiritual growth

## Doctrinal Conclusion

The doctrinal principles of The Church of Jesus Christ of Latter-day Saints completely support the inclusion of individuals with mental health and neurological needs, including those who require uncommon emotional regulation procedures or have conditions like Tourette Syndrome.

These needs:

* **DO NOT** constitute moral transgressions
* **DO NOT** affect priesthood dignity
* **DO NOT** represent sexual preferences
* **DO** deserve understanding and support
* **CAN** coexist with full spiritual life
* **DO** represent legitimate neurological diversity that requires acceptance

The implementation of these principles strengthens both individuals and the community, demonstrating the highest ideals of Christian love and divine inclusion toward all human diversity, including neurological differences.

## Doctrinal References

* **D&C 121:36-46** - Principles of priesthood
* **1 Samuel 16:7** - God looks on the heart
* **2 Nephi 26:33** - Equality before God
* **Isaiah 53:4** - Christ bore our sicknesses
* **Alma 7:11-12** - The atonement includes infirmities and sicknesses
* **"The Family: A Proclamation to the World"** - Principle of individual adaptation
* **President Gordon B. Hinckley taught:** "Our conduct in public should be above reproach; our conduct in private is even more important; it must measure up to the standard established by the Lord" (Liahona, July 2002)
* **Elder Adrián Ochoa, Liahona, October 2013**, "Physical and Emotional Health": "Taking care of your body also blesses your mind and helps you remember that you are a son or daughter of God, to have confidence in yourself and feel happy. Our emotional, physical and spiritual nature are connected"
* **Russell M. Nelson, General Conference, October 2020**, "Let God Prevail": "Stop adding to the requirements of the Gospel things that the Lord has not imposed."

## Science Reference

* **American Psychiatric Association (2021)**. Guidelines for Psychological Practice with Transgender and Gender Nonconforming People
* **Kapp, S.K., et al. (2019).** "'Being able to be myself': Autistic adults' views on stimming." Autism, 23(7), 1802–1812
* **Van der Kolk, B.A. (2014).** The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma
* **World Health Organization (2022)**. International Classification of Diseases, 11th Revision (ICD-11)

# Proposal from The First Presidency

## On Inclusion, Understanding, and Acceptance of Individuals with Mental Health Conditions

To priesthood leaders and auxiliary organizations worldwide:

Dear brothers and sisters,

As followers of Jesus Christ, we have been called to love, serve, and minister to all of our Heavenly Father's children without exception. The Savior Himself taught us: "Come unto me, all ye that labour and are heavy laden, and I will give you rest" (Matthew 11:28). This fundamental principle must guide our understanding and support for those members of our community who face unique mental health and neurological challenges, including conditions such as Tourette Syndrome, autism, ADHD, and other neurological differences.

### Principles of Inclusion and Understanding

#### Harmony with The Family: A Proclamation to the World

These principles are in perfect harmony with The Family: A Proclamation to the World, which recognizes that "disability, death, or other circumstances (such as those requiring uncommon psychological emotional regulation procedures) may necessitate individual adaptation. Extended family members should provide support when needed."

#### Full Access to Priesthood and Ordinances

We reaffirm that mental health and neurological conditions, including those requiring uncommon psychological emotional regulation procedures or conditions such as Tourette Syndrome, do not deprive any worthy member of access to the priesthood or sacred ordinances and service in the Church. This includes situations where a person's emotional or neurological well-being requires:

* Specific clothing items
* Medical or therapeutic devices
* Bandages or support products
* Diapers or other personal care accessories
* Any other elements necessary for emotional or neurological regulation
* Involuntary movements or necessary regulatory behaviors (such as tics in Tourette Syndrome)

These elements and behaviors, when part of an inherent neurological condition or a healing process supervised or not by mental health professionals (that may or may not last a lifetime), and even if they do not have a need or do not make use of their primary purpose, must be respected and permitted in all Church buildings (if they comply with Church standards) and home activities.

### Call to Empathy and Understanding

#### Neurological need and not a whim

It is important to understand that many behaviors or needs for uncommon emotional regulation are not voluntary choices or whims, but legitimate neurological responses. Strategies such as tics in Tourette Syndrome, or certain self-regulation rituals following traumatic experiences, or "stimming" in autism are necessary adaptive mechanisms. Suppressing them without understanding can cause real distress, not only interrupting emotional self-regulation, but can erode marital intimacy (in the case of marriages), generate chronic stress, reactivate trauma. Forced suppression of essential regulatory mechanisms, inhibiting bodily presence, emotional security and, with it, the capacity for connection in marriage. Therefore, they should be seen as valid needs that deserve respect and support. **Validating and respecting each spouse's regulatory needs strengthens mutual trust, restores emotional security, and creates the conditions for full, consensual, and sacred marital intimacy**.

#### Do Not Judge

We urge all members, leaders, and families to refrain from making judgments about mental health and neurological situations that may seem uncommon or difficult to understand, including conditions such as Tourette Syndrome, involuntary movements, or specific regulatory needs. Let us remember that "man looketh on the outward appearance, but the Lord looketh on the heart" (1 Samuel 16:7).

#### Do Not Exclude

No behavior related to mental health conditions or neurological differences should be grounds for exclusion from our congregations, activities, or worship services, even in family settings. Diversity in forms of healing, recovery, and neurological regulation should be seen as a manifestation of our Heavenly Father's infinite compassion.

#### Do Not Misinterpret

We recognize that we often do not know the background, trauma, neurological conditions, or circumstances that have led a person to need uncommon specific forms of emotional or neurological regulation. It should not be seen as "This makes no sense, teaching this is wrong and is trauma for children and the rising generation." Instead of making assumptions, **we should approach with humility and genuine desire to understand.** Let us remember that our calling is to love and serve, not to diagnose or 'correct' what we might not fully understand

#### Do Not Coerce

**No member, leader, family member, or friend should use emotional blackmail, spiritual pressure, or relational manipulation to demand that a person abandon legitimate emotional regulation procedures.** Phrases such as "if you really loved God, you would stop that," "you can't participate fully if you continue like this," "cannot use the priesthood," or "this is affecting the whole family" constitute forms of coercion that cause spiritual, emotional, and neurological harm This includes any type of direct or indirect harassment, in-person or virtual.

The doctrine of the Gospel teaches that the priesthood should be exercised "by persuasion, by long-suffering, by gentleness and meekness, and by love unfeigned" (Doctrine and Covenants 121:41). **Coercion does not come from God, but from human misunderstandings.** Forcing the abandonment of consolidated regulatory needs—without clinical understanding or compassionate support—is not only ineffective, but can reactivate trauma, generate isolation, and erode testimony.

True love **never conditions belonging, service, or spiritual dignity** on compliance with unrevealed standards. Genuine inclusion respects the emotional and neurological agency of each soul, just as the Savior did with all those whom He healed without requiring prior change.

#### Do Not Confuse with Sexual Preferences

It is fundamental to understand that uncommon emotional regulation procedures **do not constitute sexual preferences.** Contemporary science has demonstrated that these mechanisms are adaptive neurological responses, not expressions of sexual orientation or attraction. Confusing legitimate regulatory needs with sexual preferences generates unnecessary stigmatization, spiritual exclusion based on misunderstandings, and distance from the Savior due to lack of understanding. **Emotional regulation is intrapersonal and self-regulatory; sexual orientation is interpersonal and relational.** We must apply objective clinical criteria and not make assumptions based on the external appearance of behaviors.

#### Do Not Ridicule and Denigrate

It is fundamental that we avoid any form of mockery, contempt, or language that degrades those who experience uncommon emotional or neurological regulation needs. Ridiculing behaviors such as tics, regulatory movements, use of support devices, clothing items, personal care elements, or authentic emotional expressions not only causes deep harm, but directly contradicts the commandment to love one another as Christ loved us. Denigrating someone for their mental health or neurological condition—whether through words, gestures, subtle exclusions, or attitudes of superiority—is to deny the inherent dignity that each soul possesses as a son or daughter of God. Instead, **we are called to cultivate an environment of reverent respect, where vulnerability is welcomed with tenderness** and where difference is not tolerated, but celebrated as part of divine diversity in the human family.

### Our Christian Commitment

#### Process of understanding and self-discovery

There are people who have sought to understand their entire lives why they have certain behaviors or perform uncommon psychological emotional regulation procedures that are difficult to explain. Many understand this from their youth, others at an older age. And there are those who never manage to know why this happens to them, but all go through a painful path of misunderstanding, intolerance, marginalization, being judged and sanctioned for something they don't even fully understand. Achieving understanding and "endure it well" is what they seek, and feeling God's love and the compassion and empathy that there is no intentionality in their conduct.

#### Extending Unconditional Love

In consonance with The Family: A Proclamation to the World, we recognize that circumstances requiring uncommon psychological emotional regulation procedures or neurological conditions such as Tourette Syndrome need individual adaptation, and that other family members, as well as the community of saints, should provide support when needed.

As a community of saints, we commit to:

* Offer love without conditions or reservations
* Practice active empathy and genuine understanding toward neurological differences
* Strengthen bonds of brotherhood and love
* Make necessary adaptations according to individual circumstances
* Create safe spaces where all can heal and grow
* Foster understanding, inclusion and teach these values to children and the rising generation
* Seek those who may have been affected by not knowing these things
* Accept that conditions like Tourette Syndrome require understanding, not correction

### Guidance for Leaders

Local priesthood and auxiliary organization leaders should:

* Receive with love and patience all members, regardless of their specific mental health and neurological needs
* Recognize that, according to The Family: A Proclamation to the World, circumstances requiring uncommon psychological emotional regulation procedures or neurological conditions such as Tourette Syndrome need individual adaptation
* Consider that neurological needs must be taken into account when identifying unusual or uncommon situations
* Consult with mental health and neurology professionals when appropriate and with the member's consent
* Make necessary physical and procedural adaptations in buildings and programs
* Educate congregations about the importance of inclusion and understanding of neurological differences
* Accompany families that require help in the individual adaptation process, in mutual understanding
* Facilitate extended family members and community members to provide support when needed
* Provide ongoing support resources and training on neurodi versity
* Understand that conditions like Tourette Syndrome and other emotional regulation rituals require acceptance, not correction
* Identify situations of intolerance, due to not understanding the context, requires guidance and compassion for those affected
* Recognize that if they have affected in any way those who have these neurological needs, they should apologize for what happened and for the lack of understanding and demonstrate greater love and compassion
* Not confuse uncommon emotional regulation procedures with sexual preferences, applying objective clinical criteria and avoiding assumptions based on the external appearance of behaviors.

## Message of Hope

We testify that the atonement of Jesus Christ encompasses all aspects of human suffering, including mental health struggles and neurological differences. Every person is precious in God's sight, and every path of healing and every form of neurological regulation is sacred when sought with faith and the guidance of the Holy Spirit.

We invite all families, wards, and stakes to become refuges of love, understanding, and support for those facing unique challenges in their mental health and neurological journey, including individuals with Tourette Syndrome and other neurodivergent conditions. In doing so, we not only bless the lives of others, but we also draw closer to the Christian ideal of true unity and love toward all human diversity.

"Wherefore receive ye one another, as Christ also received us to the glory of God" (Romans 15:7).

Sincerely, The First Presidency

The Church of Jesus Christ of Latter-day Saints

This statement should be read in all sacrament meetings and distributed to all local leaders for immediate implementation.